SEVEN HILLS PEDIATRICS

We are pleased to welcome you to our practice and thank you for choosing us. If you have been here before, we would like to thank you for continuing to choose us. We are committed to providing quality patient care. The entire staff is at your service to answer your questions and assist you in completing the enclosed forms.

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION: I hereby authorize Seven Hills Pediatrics to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

A federal regulation, known as the "HIPAA Privacy Rule", requires that we provide you a detailed notice in writing of our privacy practices. It also requires us to address any special needs you may have to assure you patient information is kept confidential.

May we leave a message on your answering machine if you are not available?	Yes	No
May we leave results of diagnostic test if you are not available?	Yes	No
May we call you at work with test results or health related issues? Work #_____	Yes	No
Other than yourself, do you authorize our office to discuss health information with another family member(s) or Spouse?	Yes	No

If so whom: _____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

Patient Name _____ Signature _____

Relationship to Patient _____ Date _____